



Contents lists available at ScienceDirect

Journal of Forensic and Legal Medicine

journal homepage: www.elsevier.com/jflm



Personal View

David Jenkins Memorial Lecture 2008 ☆

Tria Juncta in Uno – The Faculty of Forensic and Legal Medicine

Ian F. Wall MB ChB (Hons), FFFLM FRCGP DMJ DOccMed (Professor, Senior Lecturer)*

David Jenkins Professor of Forensic and Legal Medicine, Faculty of Forensic and Legal Medicine (RCP) and Honorary Senior Lecturer in Forensic Medicine and Bioethics, University of Central Lancashire, UK

ARTICLE INFO

Article history:

Received 19 February 2009

Received in revised form 3 April 2009

Accepted 6 April 2009

Available online 29 May 2009

Keywords:

Forensic physician

Standards

Training

Career intentions

ABSTRACT

The David Jenkins Memorial Lecture given at the Annual General Meeting of the Faculty of Forensic and Legal Medicine on 6 June 2008 at Maidstone, Kent.

© 2009 Elsevier Ltd and Faculty of Forensic and Legal Medicine. All rights reserved.

I have to admit that I am not a Latin scholar – so no doubt many of you will now be wondering why I have chosen a Latin motto for my lecture – but hopefully all will shortly be revealed. In this presentation, I want to explore some historical links in relation to the development of the Faculty and this lecture, discuss some issues in relation to training of forensic physicians and finally mention the research project that the David Jenkins Trust fund has enabled me to undertake.

By way of introduction I want to explain some very tenuous links between my *alma mater*, the Royal College of Physicians and the title of this lecture. I am sure you will be aware of the common foxglove – *digitalis purpurea*. To appreciate its importance, we need to go back to the time of William Withering, who was born in 1741, and who graduated from Edinburgh Medical School in 1766 and started work as a consultant at Stafford Royal Infirmary the following year! Eight years later, he was appointed as a physician to Birmingham General Hospital, following the suggestion of Erasmus Darwin (the grandfather of Charles Darwin). Not only was Withering a doctor but he was also a geologist, chemist and botanist. After a chance observation in 1775 of an improvement in a patient with severe dropsy who should have died, he confirmed that extracts of the foxglove plant could help certain such cases. Over the ensuing 9 years he carefully tried out different preparations of various parts of the plant and documented 156 cases where he had employed digitalis and described the effects and the best

and safest way of using it. One of these cases was a patient whom Erasmus Darwin had asked Withering for a second opinion. In 1785, Darwin submitted a paper to the College of Physicians in London,¹ entitled “*An Account of the Successful Use of Foxglove in Some Dropsies and in Pulmonary Consumption*”. As a postscript at the end of the published volume of transactions containing Darwin’s paper it stated² “*Whilst the last pages of this volume were in press, Dr Withering of Birmingham... published a numerous collection of cases in which foxglove has been given, and frequently with good success*”. Following this Darwin and Withering became increasingly estranged, an argument ensued resulting from Darwin having accused Withering of unprofessional behaviour by effectively poaching patients – indeed this was probably a very early example of medical academic plagiarism. However, in Withering’s memory the William Withering Chair of Medicine was established at the University of Birmingham Medical School.

In 1973, Raymond (known as Bill) Hoffenberg was appointed William Withering Professor of Medicine at the University of Birmingham and it was established custom that each professor would give an inaugural lecture. I remember notices being put up around the medical school for his lecture entitled “*Tria Juncta in Uno – the role of an academic medical unit*”. Now I have to admit that as a third year medical student, I had other things to do and I did not attend his lecture! He later went on to become Sir Raymond Hoffenberg and was President of the Royal College of Physicians (RCP) from 1983 to 1989. Indeed Professor Carol Seymour was Academic Registrar when he was President and knew him well.

Sadly he died last year, but the title of his lecture always stuck in my mind, to the extent that I wondered what the precise trans-

☆ Given at the Annual General Meeting of the Faculty of Forensic and Legal Medicine on 6 June 2008 at Maidstone, Kent.

* Tel.: +44 01536 790475; fax: +44 01536 790283.

E-mail address: ianwall@doctors.org.uk

lation of the title was. So the easiest way of finding out was simply to 'Google' the phrase and of course this gave me the, not unexpected translation of, three join to become one. It is the motto of the Order of the Bath and represents the union of England, Scotland and Ireland.

But I felt the motto could be very aptly applied to the Faculty being the union of Medical Coroners, Medico-legal Advisers and Forensic Physicians – hence the title of this lecture.

So the Faculty was born in April 2006, with at that time four objectives:

- To promote for the public benefit the advancement of education and knowledge in the field of Forensic and Legal Medicine.
- To establish a career pathway in Forensic and Legal Medicine and achieve specialist recognition of the specialty.
- To develop and maintain for the public benefit the good practice of Forensic and Legal Medicine by ensuring the highest professional standards of competence and ethical integrity.
- To act as an authoritative body for the purpose of consultation in matters of educational or public interest concerning Forensic and Legal Medicine.

However, because of the need to satisfy the requirements of the Charity Commissioners, it was necessary to amend these objectives and thus formally recognize the first and third objectives above in our Standing Orders. However, that does not mean that the other objectives had to be ignored.

But whilst considering these initial objectives, I feel this would be a good opportunity to say something about David Jenkins, and whilst many people here knew him very well, some of you may not have known him. David qualified from the Middlesex in 1950, did national service in the RAF before joining the practice of Ralph Summers in Bow Road. He became police surgeon for the Metropolitan Police for "H" and "G" divisions at a time when they also had responsibility for the health of police officers and their families. He later extended his commitments to the City Police and the West End. He obtained Membership of the Faculty of Occupational Medicine and the Diploma of Medical Jurisprudence (DMJ). He subsequently became an examiner for the DMJ and a Freeman of the City of London as a liveryman of the Society of Apothecaries. He was Honorary Treasurer of the Association of Police Surgeons and President from 1986 to 1988, following which he remained on Council, becoming senior trustee of the WG Johnston Trust Fund, a position he held until he died suddenly on holiday in South Africa in March 2003. On doing a bit of further research, I discovered he examined me for part 1 of the DMJ in 1993. But more importantly, I think it can be clearly stated that David stood for everything we as a Faculty were trying to achieve when these objectives were drafted.

So what have I been trying to do as the first David Jenkins chair? There is no job description, no terms of reference but only an obligation that I undertake some form of research and give the annual David Jenkins memorial lecture. But I have seen it as something more than that and felt it was an obligation to promote the Faculty and in some way make a difference. Many of you will know that I have an interest in education and training of forensic physicians, and for the last several years had been trying to build upon the foundations established by the Association of Forensic Physicians, and in particular that of the late Dr. Michael Knight, in terms of introductory training of forensic physicians. I felt that this year would be a wonderful opportunity to try and develop this aspect of the work of the Faculty, because, after all, new doctors will be the life blood of the Faculty. Whilst I provide some expert opinions for some of the defence organisation, some of which are in response to a Coroner's Inquest, I am not a medico-legal adviser or a Coroner. And so I must apologise to my colleagues from these disciplines if I now concentrate on the work of forensic physicians.

We run, at least four times per year, an introductory residential course in clinical forensic medicine, jointly with the National Policing Improvement Agency (NPIA), held in different places around the country but most frequently in Durham, close to where one branch of NPIA is based at Harperley Hall. Repeated comments from doctors on this course were that many felt they may have had adverse incidents in relation to patient safety and/or may have missed forensic evidence due to lack of training. Some doctors admitted that they had received no training and others had received limited training of questionable quality delivered by doctors who had limited experience of and no qualifications in clinical forensic medicine. This led to an earlier research project of mine³ whose research aims were:

- To identify the characteristics of doctors commencing work in clinical forensic medicine.
- To identify if doctors had completed an introductory training course (ITC) in clinical forensic medicine and when this occurred in relation to the commencement of working.
- To identify if doctors had experienced an adverse incident in relation to patient safety through lack of training.
- To identify if doctors had experienced an adverse incident in relation to quality of forensic evidence through lack of training.

In 2005, a semi-structured postal questionnaire was sent to 806 members of the Association of Forensic Physicians in the United Kingdom (UK). The questionnaire was divided into three parts with part one asking five questions of a biographical nature, part two asking four questions relating to training and specifically if the doctor had completed an ITC and whether this was before commencing employment as a forensic physician and the third part asking, in relation to the practice of clinical forensic medicine, whether:

- They had experienced an adverse event in relation to patient safety.
- They had experienced quality issues with regard to forensic evidence.
- All new forensic physicians should complete an ITC.
- All new forensic physicians should complete an ITC before commencing forensic practice.

With respect to adverse incidents in relation to patient safety, 27 out of 357 had experienced an adverse incident; of these 25 had completed an ITC and two had not ($P > 0.001$). Adverse incidents were also reviewed by experience of doctors and it was noted that the greater the doctor's experience, the less likely a doctor was to have an adverse incident, though this was not statistically significant.

With respect to quality issues, 128 out of 357 had experienced an adverse event; of these 104 had completed an ITC and 24 had not ($P > 0.001$). These results therefore indicate that doctors who have not completed an ITC do not think they have had adverse incidents in relation to patient safety and have not missed forensic evidence. But why is this? Either the untrained doctors are so good that they rarely have adverse events or as I would suggest, the explanation is that they simply have no insight into what they are missing through lack of training. Put more simply "you don't know what you don't know".

However, I think it is crucially important that training courses are quality approved and externally accredited and as a proposal for good practice, I proposed that doctors contemplating working as a forensic physician should:

- Shadow an experienced forensic physician prior to commencing training (so that the type of work, patients and environment can be experienced first hand).

- Complete a University and Faculty accredited ITC.
- Undertake a period of practice supervised by an experienced forensic physician in accordance with the Faculty document – *A guide to practical induction training in clinical forensic medicine*.

In this way competence in clinical forensic will be achieved and adverse incidents in relation to patient safety and loss of forensic evidence will be minimised.

So, perhaps this a good opportunity to explore the issues of forensic competence further – how can this be assessed? I want to turn now to the Council for the Registration of Forensic Practitioners (CRFP). Following a series of high profile miscarriages of justice in which deficient scientific evidence was implicated, the CRFP was established in 1999 to provide a register of currently competent forensic practitioners who would be subject to regular revalidation. It now has 26 specialties registered. For doctors working in the forensic medicine field there are four sub-specialties:

- General forensic.
- Adult sexual assault.
- Child sexual abuse.
- Child physical abuse.

Some years ago, the Education and Research Committee of the former Association of Forensic Physicians (AFP) piloted the CRFP's proposed assessment process for forensic physicians. Our research indicated that the process was fundamentally flawed and failed to meet its objective of identifying forensic competence. As such, it could not be recommended to association members. Instead, the AFP proposed a modified appraisal based assessment to the CRFP who chose not to take the matter further, preferring to open registration to forensic physicians without the support of the only professional body representing this group of doctors. We understood at the time that this decision was based on an overwhelming demand from practitioners, something that has clearly not been borne out through experience. Though there were nearly 2500 registrants according to the 2006 annual review, there are currently just 17 registered in the forensic medicine field.

So it was with a degree of disappointment that I read the article 'Eight years on' by Mr. Kershaw, former Chief Executive of the Council for the Registration of Forensic Practitioners (CRFP) published in *Science and Justice*.⁴ He stated: "*CRFP has yet to make much headway with forensic medical practitioners – a group, difficult to regulate, who are seeing their forensic work steadily eroded by the development of advanced practice by nurses, radiographers and others.*" In the August 2007 newsletter of the CRFP he wrote: "*We have failed to penetrate far into the world of forensic medicine – the pathologists preferring to remain apart and the physicians succumbing to the magnetic pull of gold plating their systems, inducing paralysis.*"

One of the AFP's concerns with the proposed registration of forensic physicians was the CRFP's stated desire to register all those practising the craft, rather than just those who provide expert evidence to the courts. The Association was concerned that this might lead to misunderstandings about the extent of a registered doctor's skills and knowledge. These were clearly well founded concerns given Kershaw's comment that "*there are still too few users consulting the register before committing their cash to an 'expert'.*" And comments by another: "*Ensuring high standards of professional competence of those experts called to give evidence is crucial to the credibility of the justice system and the register is a tool that can do much to underpin that credibility*" You may wonder who said that? Tony Blair October 2004.

Registration with the CRFP does not confer expert status on a forensic physician and was never intended to. In the interests of justice, it is essential that those responsible for the register are clear on this point and do not add to any confusion. But surely

the way forward is to establish a training pathway in Forensic and Legal Medicine and achieve specialist recognition of our specialty. As a Faculty, by working with the GMC to ensure there are processes for the relicensing and recertification of forensic physicians, we can ensure fitness for purpose and I am sure this is a much better way of moving forward and achieving a professionally led medical specialty that serves the best interests of the criminal justice system and the wider public. You would therefore perhaps not be too surprised that the President and I sent a fairly robust response to the journal of *Science and Justice*!⁵ Interestingly, I think that Lord Justice Auld, who gave this lecture last year, actually got it right when he said, and I have taken this from the CRFP website: "*I believe that professional self-regulation, albeit with governmental encouragement and financial help to the extent that it may be necessary in the early days, is the better way forward*". It may be that the CRFP is the right organisation for some forensic specialties, and I really would not want to stand in the way or criticise anyone for wanting to register with the CRFP but I really do question whether it is right for forensic medicine. All I will say in relation to the CRFP is "watch this space" – I think there may be some changes over the next year.

So how can the Faculty make a difference? You will have heard earlier today, the progress we are making in terms of application for specialty status. In terms of training, Dr. Margaret Stark has established regular development training courses which, from September will be held "in house" at the RCP. But what I want to concentrate on is what has been happening in terms of introductory training. So over the past year I have been working with NPIA to develop the introductory course further with a range of high quality course materials and this has coincided with NPIA undergoing a £13 million pound development at Harperley Hall, to establish it as their national forensic centre where all their forensic training would take place. I was fortunate to be invited to represent the Faculty at the official opening of the new centre in April 2008, and from where all our future introductory training courses will be held.

But the other question that always arose as a result of the courses was how doctors could demonstrate their competence, particularly in relation to their lack of experience. Whilst all NPIA courses are quality assured, we were keen to try and achieve external accreditation of the course. We are currently working with the University of Teesside, who have a considerable amount of experience in the forensic field in its broadest sense, to external accredit the course and following a period of supervised practice by a Member of the Faculty the doctor should achieve a University Certificate in Professional Development – and we expect to have this University accreditation achieved in the next few months. Furthermore, following independent assessment of the doctor's studies and trainer assessment, including a log diary and independent assessment by one of the course tutors, a Faculty certificate of basic forensic competence can be awarded. I want to place on record the support I have received in relation to this initiative from the Academic Committee and particularly Dr. Margaret Stark, Academic Dean. But in addition I especially want to thank Mr. Peter Walton, Dean of Studies from the NPIA Forensic Centre, Harperley Hall for his support and assistance in facilitating this development – and I know Peter is in the audience tonight.

In March 2007, the first stage bid for specialty status was submitted to the Department of Health. It was necessary to put in some figures in terms of workforce planning for forensic medicine. Our vision is for a consultant led service but workforce planning is extremely difficult to predict in the formative phase of the new specialty. However we put in a figure of approximately 100 consultants and 25 specialty registrars. As part of my research project for this lecture, I therefore felt it would be interesting to explore the career aspirations of doctors commencing work in the special-

ity and what implications these aspirations have for the future of clinical forensic medicine (CFM)?

The preliminary element of this study was a literature review of what is currently known about the career intentions of forensic physicians. I first made a search via *Pub Med* using the general terms 'Forensic' and 'Physician' and 'Career' and 'Intentions' in all fields. This produced four results. Scrutinising these papers in detail revealed that these all related to career intentions of psychiatrists. However, Brook⁶ showed that a postal survey achieved high response rates and found that overseas graduates will probably remain in this country but that fewer women than men were aiming for a consultancy in general psychiatry, the rest aiming for one of the specialties. Gender differences⁷ were also apparent with women hoping to work full or maximum part time and many anticipating difficulties realising their ambitions because of being tied to one particular area on account of their husbands' employment.

Even prior to reviewing these papers for relevance these results illustrate the lack of relevant literature in the area of forensic physicians career intentions. Searches were further extended by the use of *Google Scholar* search engine. Using similar search terms this identified 2300 articles. Stark⁸ indicated an informal career structure amongst Forensic Medical Examiners (FMEs) in the Metropolitan Police from Assistant FME to Senior FME and finally Principal FME but Wells⁹ showed there was no formal career structure in Australia. A review by Meacher¹⁰ made no reference to career structure; nor did Crouch¹¹ or Pal¹² in articles about becoming a Police Surgeon. A more recent article by Payne-James et al.¹³ announcing the new Faculty, again made no mention of a lack of career structure.

Though there have been numerous studies of medical graduates¹⁴ in several years of qualifying, none of these studies have indicated clinical forensic medicine as a specific career option – all the studies have been about main stream specialties – general practice, medical specialties, surgical specialties, paediatrics, accident and emergency, obstetrics and gynaecology, radiology, pathology, psychiatry, public health medicine and a category entitled "other medical choices". It was not possible to identify what was included in "other medical choices" and this group accounted for no more than 2% of 1996, 1999 and 2000 medical graduate cohorts. Thus it can be concluded from the literature review that there is an absence of information on career intentions on doctors commencing work as forensic physicians.

In terms of study design, data was planned to be collected by means of a postal questionnaire sent to all doctors who completed the Faculty/NPIA Introductory Courses between February 2005 and November 2007. It was anticipated that there would be 100 participants. The study population was chosen because the course was the most well known course of its type in the country. Whilst other introductory courses existed, the number of doctors they trained was believed to be relatively small in comparison.

Part one of the studies was to identify the characteristics of doctors commencing work in clinical forensic medicine. Ethical committee approval was obtained from the University of Central Lancashire Faculty of Health ethics committee and an explanatory letter and questionnaire from me was sent by NPIA to participating doctors and enclosing a stamped addressed reply envelope. Care was given to the tone and content of the accompanying letter informing participants of the study and thanking them for their co-operation. A similar structured questionnaire was used to previous medical career studies¹⁵ and the questionnaire was piloted before distribution.

I used NPIA to label the envelopes so that data protection requirements could be met ensuring that personal information of name and address was not disclosed to me and to ensure the study remained completely anonymous. The questionnaire included a section on demographics to obtain age, gender, place of undergrad-

uate training, years since qualification, current position and medical experience.

So I can now report on the very preliminary information from this study. Well, the first thing to report is a problem that was encountered in terms of mailing of the questionnaires. The NPIA database had only email addresses for several doctors because course details were sent to those doctors via their employing organisations. So what has been done is that these organisations have been approached to send out the questionnaires. Currently 65 have been sent out.

In terms of replies, 30 have been received – a response rate of 46%. Part one asked various questions to identify the characteristics of doctors commencing work in clinical forensic medicine. Eight replies were from nurses and these were excluded leaving a cohort of 22 doctors that were further analysed. The majority of doctors were male – 18 out of 22–82%. Other questions included age, ethnic origin, country of birth, whether the person had a disability, medical school of training, year of graduation, qualifications and when the ITC was completed.

Part 2 of the survey asked questions about career intentions, including the specialty of work prior to commencing clinical forensic medicine, what factors motivated the person to do the work, whether they planned to work part time or full time, if they intended obtaining qualifications and what they perceived were the barriers to obtaining specialty status.

The number of respondents is so far relatively small and I have yet to do any detailed statistical analysis on the results until the issue of getting more questionnaires mailed is resolved. However, preliminary analysis of the results has shown a few trends which I will discuss in more detail and which I think may be of interest in terms of development of the Faculty and career structure.

The first thing to consider is that for the last 3 years we have been training approximately forty doctors per year. In terms of the specialty of work prior to commencing CFM, it was, perhaps not unexpectedly, general practice (82%), with a small number from medicine and emergency medicine.

In terms of the reasons why doctors commenced work as forensic physicians, the number of respondents who responded positively to a series of the statements, the following was cited as the commonest reasons: interesting career, financial rewards, flexible hours and advice from colleagues. In these days of competition for jobs and the potential for there being more doctors than there are vacancies, just one doctor commenced work because of failure to progress in their initially chosen specialty which would suggest that doctors are making forensic medicine a positive career option.

However, this question could be further analysed because doctors were able to rank the reasons why they commenced work in order of priority. Having excluded the one doctor who failed to progress in the specialty, it was possible to rank the reasons in order of popularity. This showed that advice from colleagues, flexibility of hours, interesting career, flexible conditions and intellectual challenge were the commonest reasons. So Kershaw's comments that we were only doing the work to do more "gold plating" were clearly refuted as financial rewards were not seen as a strong reason for the work. And perhaps not surprisingly, job security was of particular concern.

Part time work alongside another career was seen as the most popular way of working with just 18% working full time in the specialty. However I think this needs to be interpreted with some caution as I am aware that many outsourced companies do employ full time doctors but the problem is that as they tend not to send their doctors on our course and therefore they will not be included in the study.

So, we have a cohort of doctors who want to work in the specialty. The next question is do they want to achieve formal qualifications in forensic medicine. Well, yes they do – 68% intend to

achieve qualifications and only one person had made a positive decision not to obtain any qualifications.

But what were the barriers that doctors saw to obtaining qualifications? Perhaps not surprisingly lack of time was a problem but financial implications and lack of training courses featured the most. Privatisation of the service and restructuring in the Metropolitan police were also mentioned.

So in conclusion, I have tried to cover some of the background to the development of the Faculty, the problems that result from lack of training, the positive steps we are taking to develop training for forensic physicians, the fact we expect to gain University accreditation of our training course, that doctors still want to come into the specialty and want to achieve qualifications. And perhaps the fact that our membership base is steadily increasing and now stands at over 600 and not far from our projections are all signs for cautious optimism of the future.

So, I wonder what David Jenkins would have thought about the work of the Faculty so far – I think he would probably be pleased. President, Mrs. Jenkins, ladies and gentleman, thank you for listening.

Conflicts of Interest

None declared.

Acknowledgments

The CRFP was subsequently reviewed by the Forensic Science Regulator and formally closed on 31 March 2009. Further details of this closure can be accessed at <http://www.crfp.org.uk/>.

References

1. Medical translations. College of physicians, London. *Transaction XVI* 1785;**3**:255–86.
2. Medical translations. College of physicians, London. *Transaction XXVII* 1785;**3**:448.
3. Wall IF. Lack of training in custodial medicine in the UK – a cause for concern? *J Forensic Legal Med* 2008;**15**:378–81.
4. Kershaw A. Eight years on. *Sci Justice*. doi:10.1016/j.scijus.2007.07.07.
5. Wall IF, Norfolk GA. Regulation of forensic physicians and the CRFP. doi:10.1016/j.scijus.2007.11.001.
6. Brook P. Career intentions of senior registrars in psychiatry. *Br J Psychiatry* 1976;**128**(March):29008.
7. Gomez J, Priest RG. Women senior registrars in psychiatry: background and career intentions. *Br J Psychiatry* 1976;**128**(June):595–8.
8. Stark MM. Medical care in custody: the medical care of detainees and the prevention of tragedy – the role of the forensic medical examiner. *Clin Risk* 2000;**7**:15–9.
9. Wells D. Clinical forensic medicine in Australia. <<http://www.aic.gov.au/conferences/medicine/wells.pdf>> accessed 09.01.07.
10. Meacher M. Do forensic physicians have a future in the UK? *J Clin Forensic Med* 2005;**12**(1):42–6.
11. Crouch P. Career focus: becoming a police surgeon. *BMJ* 2005;**331**(7515):gp95.
12. Pal R. Police surgeon. *BMJ Career Focus* 2000;**320**:S2–7234.
13. Payne-James JJ, Norfolk GA, Seymour C, Burnham R. Forensic and legal medicine – a new faculty: progress at last. *BMJ Career Focus* 2006;**332**(7534):25.
14. Lambert TW, Goldacre MJ, Turner G. Career choices of United Kingdom medical graduates of 1999 and 2000: questionnaire surveys. *BMJ* 2003;**326**(7382):194–5.
15. Goldacre MJ, Evans J, Lambert TW. Media criticism of doctors: review of UK junior doctors' concerns raised in surveys. *BMJ* 2003;**326**(7390):629–30.